

NC-TOPPS Mental Health and Substance Abuse

Adolescent (Ages 12-17)

Initial Interview

****Use this form for backup only. Do not mail. Enter data into web-based system. (<https://nctopps.ncdmh.net>)**

Clinician First Initial & Last Name

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LME Assigned Consumer Record Number

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--	--

Reporting Unit

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Please provide the following information about the individual:

1. Date of Birth

		/			/		
--	--	---	--	--	---	--	--

2. County of Residence:

3. Gender

☐ Male ☐ Female

4. Is this a LME enrolled consumer?

☐ Y ☐ N ☐ Don't know

5. Please select the appropriate age/disability category(ies) for which the individual will be receiving services and supports.

(mark all that apply)

☐ Adolescent Mental Health, age 12-17

☐ Adolescent Substance Abuse, age 12-17

b. If both Mental Health and Substance Abuse, is the treatment at this time mainly provided by a...

☐ qualified professional in substance abuse

☐ qualified professional in mental health

☐ both

6. IPRS Target Populations (mark all that apply)

☐ CSMAJ ☐ CMSJD

☐ CSSAD ☐ CMMED

☐ CSIP ☐ CMDEF

☐ CSSP ☐ CMPAT

☐ CSWOM ☐ CDECI

☐ CSCJO ☐ CDSN

☐ CSDWI ☐ None of the above

7. Assessments of Functioning

a. Current Global Assessment of Functioning (GAF) Score

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8. Please indicate the DSM-IV TR diagnostic classification(s) for this individual. (See Attachment I)

9. Special Populations (mark all that apply)

☐ DWI

☐ SSI/SSDI

☐ Traumatic Brain Injury (TBI)

☐ Deaf/hard of hearing

☐ DSS Custody

☐ Juvenile Justice

☐ Criminal Justice

☐ Non-English Speaking

☐ Sexually Reactive Youth

☐ Homeless

☐ Blind

☐ Sex Offender

☐ Outpatient Commitment

☐ Child/Adolescent discharged from state-operated facility

☐ Therapeutic Foster Care

☐ None of these

10. Special Programs (mark all that apply)

☐ Multi-Systemic Therapy (MST)

☐ Intensive in-home

☐ Methamphetamine Treatment Initiative

☐ Maternal/Pregnant

☐ None of these

11. For Adolescent discharged from state-operated facility only (from 'Special Populations,' question 9: Please specify (a) from which institution the individual was discharged and (b) the date of discharge:

☐ Broughton Hospital

☐ Cherry Hospital

☐ Dorothea Dix Hospital

☐ John Umstead Hospital

☐ Whitaker School

☐ Wright School

b. Date of Discharge

		/			/		
--	--	---	--	--	---	--	--

12. For Adolescent SA individual only:

Please indicate the individual's Primary (required), Secondary (if applicable), and Tertiary (if applicable) substance problems by entering a "1" for Primary, "2" for Secondary, and "3" for Tertiary.

☐ Alcohol

☐ Methamphetamine

☐ Non-Prescription Methadone

☐ Other Amphetamines

☐ Other Non-Benzodiazepine Tranquilizers

☐ Inhalants

☐ Marijuana/Hashish

☐ Heroin

☐ PCP-Phencyclidine

☐ Other Stimulants

☐ Barbiturates

☐ Over-the-Counter

☐ Cocaine/Crack

☐ Other Opiates/Opioids

☐ Other Hallucinogens

☐ Benzodiazepine

☐ Other Non-Barbiturate Sedatives or Hypnotics

☐ Other Drug

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13. For Adolescent SA individual:

Please indicate the individual's age of first use/intoxication and how substance was taken (if applicable) of the Primary, Secondary (if applicable), and Tertiary (if applicable) substance(s).

Substance	Age of First Use/ Intoxication	How usually taken (mark only one)
Alcohol	<input type="text"/> <input type="text"/>	N/A
Marijuana/Hashish	<input type="text"/> <input type="text"/>	N/A
Cocaine/Crack	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Methamphetamine	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Heroin	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Opiates/Opioids	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Non-Prescription Methadone	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
PCP-phencyclidine	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Hallucinogens	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Amphetamines	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Stimulants	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Benzodiazepine	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Non-Benzodiazepine Tranquilizers	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Barbiturates	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Non-Barbiturate Sedatives or Hypnotics	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Inhalants	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Over-the-Counter	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other
Other Drug	<input type="text"/> <input type="text"/>	<input type="checkbox"/> Oral <input type="checkbox"/> Smoke <input type="checkbox"/> Inject <input type="checkbox"/> Inhale <input type="checkbox"/> Other

Begin Interview

14. Who is the respondent?

- ☐ Child ☐ Guardian
☐ Parent ☐ Other

15. Are you of Hispanic, Latino, or Spanish origin?

☐ Y ☐ N → (skip to 16)

b. If **yes**, please specify origin:

- ☐ Hispanic, Mexican American
☐ Hispanic, Puerto Rican
☐ Hispanic, Cuban
☐ Hispanic, Other

16. Which of these groups best describes you?

- ☐ African American/Black ☐ Alaska Native
☐ White/Anglo/Caucasian ☐ Asian
☐ Multiracial ☐ Pacific Islander
☐ American Indian/Native American ☐ Other

17. What kind of health/medical insurance do you have? (mark all that apply)

- ☐ None ☐ Medicaid
☐ Private insurance/health plan ☐ Medicare
☐ CHAMPUS or CHAMPVA ☐ Other
☐ Health Choice ☐ Unknown

18. What is the highest grade you completed or degree you received in school?

- ☐ Grade K, 1, 2, 3, 4, or 5 ☐ 2-year college/assoc. degree
☐ Grade 6, 7, or 8 ☐ 4-year college degree
☐ Grade 9, 10, 11, or 12 (no diploma) ☐ Graduate work, no degree
☐ HS diploma/GED ☐ Professional degree or more
☐ Some college or technical/vocational school

19. Are you currently enrolled in school or courses that satisfy requirements for a certification, diploma or degree? (Enrolled includes school breaks, suspensions, and expulsions)

☐ Y ☐ N → (skip to 20)

b. If **yes**, what programs are you currently enrolled in for credit? (mark all that apply)

- ☐ Alternative Learning Program (ALP)- at-risk students
☐ Academic schools (K-12) outside standard
☐ Technical/Vocational school classroom
☐ College
☐ GED Program, Adult literacy

20. For K-12 only:

- a. What grade are you currently in?
- b. For your most recent reporting period, what grades did you get most of the time? (mark only one)
☐ A's ☐ B's ☐ C's ☐ D's ☐ F's ☐ School does not use traditional grading system
- c. If school does not use traditional grading system, for your most recent reporting period, did you pass or fail most of the time? ☐ Pass ☐ Fail

21. For K-12 only: In the past 3 months, how many days of school have you missed due to...

- a. Expulsion
- b. Out-of-school suspension
- c. Truancy
- d. Are you currently expelled from regular school?
☐ Y ☐ N

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22. In the past 3 months, what best describes your employment status? (mark only one)

- ☐ Full-time work (working 35 hours or more a week) → (skip to b & c)
- ☐ Part-time work (working less than 35 hours a week) → (skip to b & c)
- ☐ Unemployed (seeking work or on layoff from a job) → (skip to 23)
- ☐ Not in labor force (not seeking work) → (skip to d & e)

b. Is this work transitional employment? ☐ Y ☐ N

c. Is this work supported employment? ☐ Y ☐ N

d. If not seeking work, what best describes your current status? (mark only one)

- | | |
|--|--|
| <input type="checkbox"/> Homemaker | <input type="checkbox"/> Incarcerated (juvenile or adult |
| <input type="checkbox"/> Student | <input type="checkbox"/> Institutionalized facility) |
| <input type="checkbox"/> Retired | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Chronic medical condition which prevents employment | |

e. If not seeking work, what best describes your current activities? (mark all that apply)

- ☐ Community service (court related)
- ☐ Structured day activity
- ☐ Unpaid vocational rehab
- ☐ Volunteer activity
- ☐ Hobbies/Social activities
- ☐ Other
- ☐ No activity

23. In the past 3 months, how often have your problems interfered with work, school, or other daily activities?

- ☐ Never
- ☐ A few times
- ☐ More than a few times

24. What is your current marital status? (include same sex partnerships as living as married)

- | | |
|--|---|
| <input type="checkbox"/> Married | <input type="checkbox"/> Separated |
| <input type="checkbox"/> Living as married | <input type="checkbox"/> Widowed |
| <input type="checkbox"/> Divorced | <input type="checkbox"/> Never been married |

25. In the past year, how many times have you moved residences? → (if none, skip to 26)

b. What was the reason(s) for your most recent move? (mark all that apply)

- ☐ Moved closer to family/friends
- ☐ Moved in with roommate
- ☐ Moved to nicer location
- ☐ Moved to safer location
- ☐ Needed more supervision
- ☐ Needed more supports
- ☐ Moved to location with more independence
- ☐ Moved to location with better access to activities and/or services
- ☐ Evicted
- ☐ Could no longer afford previous location
- ☐ Other

26. In the past 3 months, where did you live most of the time?

- | | |
|---|---|
| <input type="checkbox"/> Homeless → (skip to b) | <input type="checkbox"/> Residential program → (skip to d) |
| <input type="checkbox"/> Temporary housing → (skip to c) | <input type="checkbox"/> Facility/institution → (skip to e) |
| <input type="checkbox"/> In your or parent's/guardian's home/apt → (skip to 27) | |

b. If homeless, please specify your living situation most of the time in the past 3 months.

- ☐ Sheltered (homeless shelter)
- ☐ Unsheltered (on the street, in a car, camp)

c. If temporary housing, please specify the type of temporary housing you lived in most of the time in the past 3 months.

- ☐ Transitional housing (time-limited stay)
- ☐ Living temporarily with other(s)

d. If residential program, please specify the type of residential program you lived in most of the time in the past 3 months.

- ☐ Foster home
- ☐ Therapeutic foster home
- ☐ Level III group home
- ☐ Level IV group home
- ☐ State-operated residential treatment center
- ☐ Substance abuse residential treatment facility
- ☐ Halfway house (for Adolescent SA individual)

e. If facility/institution, please specify the type of facility you lived in most of the time in the past 3 months.

- ☐ Psychiatric Residential Treatment Facility (PRTF)
- ☐ Public institution
- ☐ Private institution
- ☐ Correctional facility

27. Was this living arrangement in your home community?

- ☐ Y ☐ N

28. In the past 3 months, who did you live with most of the time? (mark all that apply)

- | | |
|--|--|
| <input type="checkbox"/> Lived alone | <input type="checkbox"/> Foster family |
| <input type="checkbox"/> Spouse/partner | <input type="checkbox"/> Sibling(s) |
| <input type="checkbox"/> Child(ren) | <input type="checkbox"/> Other relative(s) |
| <input type="checkbox"/> Mother/Stepmother | <input type="checkbox"/> Guardian |
| <input type="checkbox"/> Father/Stepfather | <input type="checkbox"/> Friend(s)/roommate(s) |
| <input type="checkbox"/> Grandmother | <input type="checkbox"/> Other |
| <input type="checkbox"/> Grandfather | |

29. In the past 3 months, who was your primary caregiver? (mark only one)

- | | |
|---|--|
| <input type="checkbox"/> Parent(s) | <input type="checkbox"/> Spouse/partner |
| <input type="checkbox"/> Grandparent(s) | <input type="checkbox"/> Other relative(s) |
| <input type="checkbox"/> Sibling(s) | <input type="checkbox"/> Other |
| <input type="checkbox"/> Foster parent(s) | |

30. Do you have an identified public or private primary health care provider? ☐ Y ☐ N → (skip to 31)

b. When was the last time you saw this provider?

- ☐ Within the past year
- ☐ Within the past 2 years
- ☐ Within the past 5 years
- ☐ More than 5 years ago

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31. Females only: Are you currently pregnant?

☐ Y ☐ N ☐ Unsure
(skip to 32) (skip to 32)

b. How many weeks have you been pregnant?

c. Have you been referred to prenatal care? ☐ Y ☐ N

d. Are you receiving prenatal care? ☐ Y ☐ N

32. Do you have children under the age of 18?

☐ Y ☐ N → (skip to 34)

b. Do you have legal custody of all, some, or none of your children?

☐ All → (skip to e) ☐ Some ☐ None

c. Does DSS have legal custody of all, some, or none of your children?

☐ All ☐ Some ☐ None

d. Are you currently seeking legal custody of all, some or none of your children? ☐ All ☐ Some ☐ None

e. Are all, some, or none of the children in your legal custody receiving preventive and primary health care?

☐ All ☐ Some ☐ None ☐ NA (no children in legal custody)

f. How many of the children in your legal custody have been screened for mental health and/or substance abuse prevention or treatment services? ☐ All ☐ Some ☐ None ☐ NA

33. In the past year, have you been investigated by DSS for child abuse or neglect? ☐ Y ☐ N → (skip to 34)

b. For Adolescent SA individual:

Was the investigation due to an infant testing positive on a drug screen? ☐ Y ☐ N ☐ NA

34. Was your admission to treatment required by Child Welfare Services of DSS? ☐ Y ☐ N

35. In the past 3 months, how often did you participate in a. extracurricular activities?

☐ Never ☐ A few times ☐ More than a few times

b. recovery-related support or self-help groups?

☐ Never ☐ A few times ☐ More than a few times

c. organized religious activities?

☐ Never ☐ A few times ☐ More than a few times

36. For Adolescent MH individual:

Have you ever used tobacco or alcohol?

☐ Y ☐ N

37. For Adolescent MH individual:

Have you ever used illicit drugs or other substances?

☐ Y ☐ N

For Adolescent MH individual:

****If "Yes" is answered on question 36 or 37, go to question 38.**

If "No" is answered on both questions 36 and 37, go to question 39.

38. Please mark the frequency of use for each substance in the past 12 months and past month.

Substance	Past 12 Months - Frequency of Use					Past Month - Frequency of Use				
	Not Used	1-3 times monthly	1-2 times weekly	3-6 times weekly	Daily	Not Used	1-3 times monthly	1-2 times weekly	3-6 times weekly	Daily
Tobacco use (any tobacco products)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy alcohol use (≥5(4) drinks per sitting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Less than heavy alcohol use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana or hashish use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cocaine or crack use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heroin use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other opiates/opioids	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other drug use <input type="text"/> <input type="text"/> (enter code from list below)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Drug Codes

5=Non-prescription Methadone

7=PCP

8=Other Hallucinogen

9=Methamphetamine

10=Other Amphetamine

11=Other Stimulant

12=Benzodiazepine

13=Other Tranquilizer

14=Barbiturate

15=Other Sedative or Hypnotic

16=Inhalant

17=Over-the-Counter

22=OxyContin (Oxycodone)

29=Ecstasy (MDMA)

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39. In the past month, how many cigarettes did you smoke per day, on average? (enter 0, if none) <input type="text"/> <input type="text"/>	46. Have you ever been forced or pressured to do sexual acts? <input type="checkbox"/> Y <input type="checkbox"/> N → (skip to 47) <input type="checkbox"/> Deferred → (skip to 47) b. What is the most recent time that you have been forced or pressured to do sexual acts? <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> Within the past year <input type="checkbox"/> Within the past 5 years <input type="checkbox"/> More than 5 years ago
40. For Adolescent SA individual: How long have you been abstinent from alcohol or other drugs at this time? (do not include nicotine or tobacco products) (enter 0 if not abstinent) <input type="text"/> <input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Mos. <input type="checkbox"/> Wks. <input type="checkbox"/> Yrs.	47. In the past 3 months, how often have you ever forced or pressured someone to do sexual acts? <input type="checkbox"/> Never <input type="checkbox"/> A few times <input type="checkbox"/> More than a few times <input type="checkbox"/> Deferred
41. For Adolescent SA individual: What is the longest, uninterrupted period you have ever maintained abstinence from alcohol or other drugs since you started using regularly? (do not include nicotine or tobacco products) <input type="text"/> <input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Mos. <input type="checkbox"/> Wks. <input type="checkbox"/> Yrs.	48. In the past 3 months, how often have you tried to hurt yourself or cause yourself pain on purpose (such as cut, burned, or bruised self)? <input type="checkbox"/> Never <input type="checkbox"/> A few times <input type="checkbox"/> More than a few times
42. For Adolescent SA individual: Have you ever used a needle to get any drug injected under your skin, into a muscle, or into a vein for nonmedical reasons? <input type="checkbox"/> Y <input type="checkbox"/> N → (skip to 43) <input type="checkbox"/> Deferred → (skip to 43) b. What is the most recent time that you ever used a needle in that way? <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> Within the past year <input type="checkbox"/> Within the past 5 years <input type="checkbox"/> More than 5 years ago	49. In your lifetime, have you ever attempted suicide? <input type="checkbox"/> Y <input type="checkbox"/> N
43. Have you ever participated in any of the following activities without a condom being used? had sex with someone who was <u>not your spouse or primary partner</u> [or] <u>knowingly</u> had sex with someone who injected drugs [or] traded, gave, or received sex for drugs, money, or gifts? <input type="checkbox"/> Y <input type="checkbox"/> N → (skip to 44) <input type="checkbox"/> Deferred → (skip to 44) b. What is the most recent time that you did any one of these activities? <input type="checkbox"/> Within the past 3 months <input type="checkbox"/> Within the past year <input type="checkbox"/> Within the past 5 years <input type="checkbox"/> More than 5 years ago	50. In the past 3 months, how often have you had thoughts of suicide? <input type="checkbox"/> Never <input type="checkbox"/> A few times <input type="checkbox"/> More than a few times
44. In the past 3 months, how often have you been hit, kicked, slapped, or otherwise physically hurt? <input type="checkbox"/> Never → (skip to 45) <input type="checkbox"/> A few times <input type="checkbox"/> More than a few times <input type="checkbox"/> Deferred → (skip to 45) b. By whom were you physically hurt? (mark all that apply) <input type="checkbox"/> Spouse/partner <input type="checkbox"/> Other adult <input type="checkbox"/> Parent <input type="checkbox"/> Other child <input type="checkbox"/> Sibling <input type="checkbox"/> Gang member(s) <input type="checkbox"/> Your child	51. In the past 3 months, how often have you used faith, prayer, religious or other spiritual involvement to help you with daily living? <input type="checkbox"/> Never <input type="checkbox"/> A few times <input type="checkbox"/> More than a few times
45. In the past 3 months, how often have you hit, kicked, slapped, or otherwise physically hurt someone? <input type="checkbox"/> Never <input type="checkbox"/> A few times <input type="checkbox"/> More than a few times <input type="checkbox"/> Deferred	52. In the past 3 months, how often have you carried a weapon, such as a knife or handgun? <input type="checkbox"/> Never <input type="checkbox"/> A few times <input type="checkbox"/> More than a few times
	53. For Adolescent SA individual: In your lifetime, how many times have you been arrested or had a petition filed for adjudication for any offense including DWI? <input type="text"/> <input type="text"/> (enter 0 if none and skip to 55) b. In your lifetime, how many times have you been arrested for a misdemeanor offense including DWI? <input type="text"/> <input type="text"/> c. In your lifetime, how many times have you been arrested for a felony offense? <input type="text"/> <input type="text"/>
	54. For Adolescent MH individual: In the past year, how many times have you been arrested or had a petition filed for adjudication for any offense including DWI? <input type="text"/> <input type="text"/> (enter 0 if none)
	55. In the past month, how many times have you been in trouble with the law? <input type="text"/> <input type="text"/> (enter 0 if none and skip to 57)

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56. In the past month, how many times have you been arrested or had a petition filed for adjudication for any offense including DWI? (excluding traffic violations)

(enter 0 if none and skip to 57)

b. In the past month, how many times have you been arrested for a misdemeanor offense including DWI?

c. In the past month, how many times have you been arrested for a felony offense?

57. Are you currently under any type of correctional supervision in the....

a. *adult* correctional system? ☐ Y ☐ N

b. *juvenile* correctional system? ☐ Y ☐ N

58. Is your admission to treatment required by the courts or the criminal or juvenile justice system? ☐ Y ☐ N

59. For Adolescent SA individual:

In the past 3 months prior to your current admission, how many weeks were you enrolled in substance abuse treatment (not including detox)? (enter 0, if none)

60. In the past 3 months, approximately how many...

a. **telephone** contacts to an emergency crisis facility did you have?

b. **face-to-face** contacts to an emergency crisis facility or mobile crisis unit did you have?

c. **visits** to a hospital emergency room did you have?

e. **nights** in a facility-based crisis service did you spend?

f. **nights** in facility-based respite did you spend?

g. **admissions** to a detox facility did you have?

h. **nights** in an inpatient facility for mental health treatment did you spend?

i. **nights** in an inpatient facility for substance abuse treatment did you spend?

j. **nights** in a medical/surgical hospital did you spend? (excluding birth delivery)

k. **nights** homeless (sheltered or unsheltered) did you spend?

l. **nights** in detention, jail, or prison did you spend (adult or juvenile system)?

61. In your lifetime, approximately how many prior admissions (not including this admission) to...

a. outpatient mental health treatment have you had?

b. outpatient substance abuse treatment have you had?

c. a detox facility have you had?

d. an inpatient hospital or residential facility for mental health treatment have you had?

e. an inpatient hospital or residential facility for substance abuse treatment have you had?

f. a therapeutic foster home and family group home have you had?

g. Level III group home have you had?

h. Level IV residential treatment facility have you had?

i. a psychiatric residential treatment facility (PRTF) have you had?

62. How many active, stable relationship(s) with adult(s) who serve as positive role models do you have? (i.e., member of clergy, neighbor, family member, coach)

☐ None ☐ 1 or 2 ☐ 3 or more

63. How supportive do you think your family and/or friends will be of your treatment and recovery efforts?

☐ Not supportive
☐ Somewhat supportive
☐ Very supportive
☐ No family/friends

64. How well have you been doing in the following areas of your life in the past year?

	Excellent	Good	Fair	Poor
a. Emotional well-being	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Physical health	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Relationships with family or significant others	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

65. Did you receive a list or options, verbal or written, of places to receive services?

☐ Yes, I received a list or options
☐ No, I came here on my own
☐ No, nobody gave me a list or options

66. Was your first service in a time frame that met your needs?

☐ Y ☐ N

NC-TOPPS Mental Health and Substance Abuse

Adolescent (Ages 12-17)

Initial Interview

****Use this form for backup only. Do not mail. Enter data into web-based system. (<https://nctopps.ncdmh.net>)**

67. Did you have difficulty entering treatment because of problems with... (mark all that apply)

- ☐ No difficulties prevented you from entering treatment
- ☐ Active mental health symptoms (anxiety or fear, agoraphobia, paranoia, hallucinations)
- ☐ Active substance abuse symptoms (addiction, relapse)
- ☐ Physical health problems (severe illness, hospitalization)
- ☐ Family or guardian issues (controlling spouse, family illness, child or elder care, domestic violence, parent/guardian cooperation)
- ☐ Treatment offered did not meet needs (availability of appropriate services, type of treatment wanted by consumer not available, favorite therapist quit, etc.)
- ☐ Engagement issues (AWOL, doesn't think s/he has a problem, denial, runaway, oversleeps)
- ☐ Cost or financial reasons (no money for cab, treatment cost)
- ☐ Stigma/Embarrassment
- ☐ Treatment/Authorization access issues (insurance problems, waiting list, paperwork problems, red tape, lost Medicaid card, IPRS target populations, Value Options, referral issues, citizenship, etc.)
- ☐ Language or communication issues (foreign language issues, lack of interpreter, etc.)
- ☐ Legal reason (incarceration, arrest)
- ☐ Transportation/Distance to provider
- ☐ Scheduling issues (work or school conflicts, appointment times not workable, no phone)

68. How important to you now is help or services in any of the following areas?

	<u>Not</u> <u>Important</u>	<u>Somewhat</u> <u>Important</u>	<u>Very</u> <u>Important</u>	<u>NA</u>
a. Educational improvement_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Finding or keeping a job_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Food_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Transportation_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Child care_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Family and/or peer relationships_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Medical care_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Psychological/emotional care_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Legal issues_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Interpreter (deaf or foreign language)_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Tobacco use cessation_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Respite _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Appropriate living setting_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Crisis services_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Cessation of alcohol/drugs_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Management of finances_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
q. Housing (basic shelter or rent subsidy)_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

69. In the past month, how would you describe your mental health symptoms?

- ☐ Extremely Severe
- ☐ Severe
- ☐ Moderate
- ☐ Mild
- ☐ Not present

70. For Adolescent SA individual:

Does the consumer have a current written consent in her/his consumer record for the DMHDDSAS to share NC-TOPPS Interviews with the consumer's assigned LME in accordance with 42 CFR, Part 2, HIPAA and NC Statute? ☐ Y ☐ N

End of interview

**Enter data into web-based system:
<https://nctopps.ncdmh.net>**

Do not mail this form

Attachment I:

DSM-IV TR Diagnositic Classifications

Childhood Disorders

- ☐ Learning Disorders (315.00, 315.10, 315.20, 315.90)
- ☐ Autism and pervasive development (299.00, 299.10, 299.80)
- ☐ Motor skills disorders (315.40)
- ☐ Attention deficit disorder (314.xx, 314.90)
- ☐ Communication disorders (307.00, 307.90, 315.31, 315.39)
- ☐ Conduct disorder (312.80)
- ☐ Childhood disorders-other (307.30, 309.21, 313.23, 313.89, 313.90)
- ☐ Disruptive behavior (312.90)
- ☐ Mental Retardation (317, 318.00, 318.10, 318.20, 319)
- ☐ Oppositional defiant disorder (313.81)

Substance-Related Disorders

- ☐ Alcohol abuse (305.00)
- ☐ Alcohol dependence (303.90)
- ☐ Drug abuse (305.20, 305.30, 305.40, 305.50, 305.60, 305.70, 305.90)
- ☐ Drug dependence (304.00, 304.10, 304.20, 304.30, 304.40, 304.50, 304.60, 304.80, 304.90)

Schizophrenia and Other Psychotic Disorders

- ☐ Schizophrenia and other psychotic disorders (293.xx, 295.xx, 297.10, 297.30, 298.80, 298.90)

Mood Disorders

- ☐ Dysthymia (300.40)
- ☐ Bipolar disorder (296.xx)
- ☐ Major depression (296.xx)

Anxiety Disorders

- ☐ Anxiety disorders (other than PTSD) (293.89, 300.00, 300.01, 300.02, 300.21, 300.22, 300.23, 300.29, 300.30, 308.30)
- ☐ Posttraumatic Stress Disorder (PTSD) (309.81)

Adjustment Disorders

- ☐ Adjustment disorders (309.xx)

Personality, Impulse Control, and Identity Disorders

- ☐ Personality disorders (301.00, 301.20, 301.22, 301.40, 301.50, 301.60, 301.70, 301.81, 301.82, 301.83, 301.90)
- ☐ Impulse control disorders (312.31, 312.32, 312.33, 312.34, 312.39)
- ☐ Sexual and gender identity disorders (302.xx, 306.51, 607.84, 608.89, 625.00, 625.80)

Delerium, Dementia, & Other Cognitive Disorders

- ☐ Delirium, dementia, and other cognitive disorders (290.xx, 290.10, 293.00, 294.10, 294.80, 294.90, 780.09)

Disorders Due to Medical Condition and Medications

- ☐ Mental disorders due to medical condition (306, 316)
- ☐ Medication induced disorders (332.10, 333.10, 333.70, 333.82, 333.90, 333.92, 333.99, 995.2)

Somatoform, Eating, Sleeping & Factitious Disorders

- ☐ Somatoform, eating, sleeping, and factitious disorders (300.xx, 300.11, 300.70, 300.81, 307.xx)

Dissociative Disorders

- ☐ Dissociative disorders (300.12, 300.13, 300.14, 300.15, 300.60)

Other Disorders

- ☐ Other mental disorders (Codes not listed above)
- ☐ Other clinical issues (V-codes)